



BED INVENTORY

State Form 4332 (R8/01-02)

Indiana State Department of Health-Division of Long Term Care

Name of Facility											
Street Address											
City					County				Zip+4		
PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS: Each room should be listed only once and listed in numerical order under each classification column.										Room No.	No. Beds
Title 18 SNF = Medicare ONLY beds Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) Title 19 NF = Medicaid All licensed beds must be listed. NCC = Non-Certified Comprehensive Residential Level of Care										8	2
										9	2
										10	2
										11	3
										12	2
										20	2
Title 18 SNF		Title 18/19 SNF/NF		Title 19 NF				NCC		Residential	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF		Total 19 NF				Total NCC		Total Residential	

Current SNF Census		
Current SNF/NF Census		
Current NF Census		
Current NCC Census		
Current Residential Census		
TOTAL CURRENT CENSUS		
TOTAL LICENSED CAPACITY		

NOTE

Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed and certified for.

Completed by	Position	Date
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